Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SCOTT & WHITE HOSPITAL MEDICAL CENTER
8760A RESEARCH BLVD 183
AUSTIN TX 78758

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-10-1880-01

MFDR Date Received
NOVEMBER 17, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary on Table of Disputed Services: "authorized no payments".

Requestor's Position Summary dated January 21, 2010: "They paid $996.78 out of the fee schedule which was $4821.60. they still owe $3824.82 towards the fee schedule."

Amount in Dispute: $3,824.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual Insurance Company contacted the requestor regarding the correct coding in order to ensure the requestor understood what the correct code is. The requestor verbalized the correct coding to use. For this reason Texas Mutual will issue payment of the maximum allowable reimbursement under separate cover."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 10, 2008	CPT Code 22554-AS	$3,824.82	$0.00
	CPT Code 22585-AS		$0.00
	CPT Code 22845-AS		$0.00
	CPT Code 22851-AS		$0.00
	CPT Code 63081-AS		$0.00

TOTAL		$3,824.82	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §133.4, effective July 27, 2008, requires the insurance carrier to notify providers of contractual agreements for informal and voluntary networks.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - CAC-29-The time limit for filing has expired.
   - 731-134.801 & 133.20 provider shall not submit a medical bill later than the 95th day after the date of service, for service on or after 9/1/05.
   - 732-Modifier-82 is not the appropriate modifier for an PA.
   - CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.
   - CAC-4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - 732-Accurate coding is essential for reimbursement. Services are not reimbursable as billed. CPT and/or modifier billed incorrectly.
   - 891-The insurance company is reducing or denying payment after reconsideration.
   - 732-Reimbursement denied as 2 different modifiers for surgical assistants has been billed.
   - CAC-45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
   - 793-Reduction due to PPO contract. PPO contract was applied by FOCUS/First Health.
   - CAC- W1-Workers Compensation state fee schedule adjustment.
   - 790-This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - 920-Reimbursement is being allowed based upon a dispute.

Issues

1. Does a timely filing issue exist in this dispute?
2. Does the documentation support notification requirements in accordance with 28 Texas Administrative Code §133.4?
3. Is the requestor entitled to additional reimbursement for CPT code 22554?
4. Is the requestor entitled to additional reimbursement for CPT code 22585?
5. Is the requestor entitled to additional reimbursement for CPT code 22845?
6. Is the requestor entitled to additional reimbursement for CPT code 22851?
7. Is the requestor entitled to additional reimbursement for CPT code 63081?

Findings

1. The respondent initially denied reimbursement for the disputed services based upon "CAC-29 and 731." A review of the submitted documentation finds that the respondent did not maintain this denial reason and issued payment of $996.78; therefore, a timely filing issue does not exist in this dispute.
2. 28 Texas Administrative Code §133.4(g) states "Noncompliance. The insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network if:
   (1) the notice to the health care provider does not meet the requirements of Labor Code §413.011 and this section; or

   (2) there are no required contracts in accordance with Labor Code §413.011(d-1) and §413.0115."

   On March 29, 2012, the Division requested a copy of the written notification to the health care provider

pursuant to 28 Texas Administrative Code §133.4. No documentation was provided to sufficiently support that the respondent notified the requestor of the contracted fee negotiation in accordance with 28 Texas Administrative Code §133.4(g).

28 Texas Administrative Code §133.4(h) states "Application of Division Fee Guideline. If the insurance carrier is not entitled to pay a health care provider at a contracted rate as outlined in subsection (g) of this section and as provided in Labor Code §413.011(d-1), the Division fee guidelines will apply pursuant to §134.1(e)(1) of this title (relating to Medical Reimbursement), or, in the absence of an applicable Division fee guideline, reimbursement will be based on fair and reasonable reimbursement pursuant to §134.1(e)(3) of this title."

The Division concludes that the respondent's is not entitled to pay the requestor at a contracted fee reduction; therefore, the disputed services will be reviewed per applicable Division rules and guidelines.

3. 28 Texas Administrative Code §134.203(b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor appended modifier AS to CPT code 22554, 22585, 22845, 22851 and 63081. Modifier AS is defined as "Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery."

   Per Trailblazer Health Enterprises, LLC, Surgery Manual published December 2008, "The allowed amount for assistant-at-surgery services is 16 percent of the physician fee schedule. The allowable for the assistant-at-surgery services performed by an NP, PA or CNS is 85 percent of the 16 percent allowed based on the physician fee schedule."

   The services in dispute were rendered by a PA.

   CPT code 22554 is defined as "Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2."

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2008 DWC conversion factor for this service is 66.32.

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 76508, which is located in Bell County. The Medicare conversion factor for Bell County is 38.087.

   The Medicare participating amount for code 22554 in Bell County is $1,155.88.

   This code is subject to multiple procedure rule discounting; therefore, $1,155.88 = $577.94.

   Using the above formula, the MAR is $1,006.35.

   The requestor appended modifier AS. Per Medicare Surgery Policy Manual, the PA receives 85 percent of 16 percent of $1,006.35 = $136.85. The respondent paid $273.73. The requestor is due $0.00 additional reimbursement.

4. CPT Code 22585 is defined as "Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)."

   The Medicare participating amount for code 22585 in Bell County is $317.80.

This code is not subject to multiple procedure rule discounting.

Using the above formula, the MAR is $553.38.

The requestor appended modifier AS. Per Medicare Surgery Policy Manual, the PA receives 85 percent of 16 percent of $553.38 = $75.25. The respondent paid $75.26. The requestor is due $0.00 additional reimbursement.

5. CPT Code 22845 is defined as "Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)."

   The Medicare participating amount for code 22845 in Bell County is $694.60.

   This code is not subject to multiple procedure rule discounting.

   Using the above formula, the MAR is $1209.49.

   The requestor appended modifier AS. Per Medicare Surgery Policy Manual, the PA receives 85 percent of 16 percent of $1209.49 = $164.48. The respondent paid $164.49. The requestor is due $0.00 additional reimbursement.

6. CPT code 22851 is defined as "Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)."

   The Medicare participating amount for code 22851 in Bell County is $384.66.

   This code is not subject to multiple procedure rule discounting.

   Using the above formula, the MAR is $669.80.

   The requestor appended modifier AS. Per Medicare Surgery Policy Manual, the PA receives 85 percent of 16 percent of $669.80 = $91.08. The respondent paid $91.09. The requestor is due $0.00 additional reimbursement.

7. CPT code 63081 is defined as "Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment."

   The Medicare participating amount for code 63081 in Bell County is $1,654.27.

   This code is not the principal procedure; therefore, it is not subject to multiple procedure rule discounting.

   Using the above formula, the MAR is $2,723.83.

   The requestor appended modifier AS. Per Medicare Surgery Policy Manual, the PA receives 85 percent of 16 percent of $2,723.83 = $370.43. The respondent paid $370.44. The requestor is due $0.00 additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		2/21/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC

Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.